SELECT JOINT COMMISSION ON MEDICAID OVERSIGHT

Legislative Services Agency
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MEETING MINUTES[1]

Meeting Date:	**October 17, 2001**
Meeting Time:	**1:00 P.M.**
Meeting Place:	**State House, 200 W. Washington St., Senate Chambers**
Meeting City:	**Indianapolis, Indiana**
Meeting Number:	**4**

Members Present: **Sen. Patricia Miller, Chairperson; Sen. Robert Meeks; Sen. Steve Johnson; Sen. Rose Antich; Sen. Vi Simpson; Rep. Charlie Brown; Rep. William Crawford; Rep. Susan Crosby; Rep. Mary Kay Budak; Rep. David Frizzell.**

Members Absent: **Sen. Samuel Smith; Rep. Gary Dillon.**

Senator Miller called the meeting to order at approximately 1:10 P.M. Senator Miller distributed to the Commission a copy of the bills from last session concerning Medicaid that the Governor vetoed. (See Exhibit 1.) Senator Miller also distributed preliminary draft (PD) 3365 to update the Indiana Code concerning the change of names of Medicaid bodies. (See Exhibit 2.)

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[1] Exhibits and other materials referenced in these minutes can be inspected and copied in the Legislative Information Center in Room 230 of the State House in Indianapolis, Indiana. Requests for copies may be mailed to the Legislative Information Center, Legislative Services Agency, 200 West Washington Street, Indianapolis, IN 46204-2789. A fee of $0.15 per page and mailing costs will be charged for copies. These minutes are also available on the Internet at the General Assembly homepage. The URL address of the General Assembly homepage is http://www.ai.org/legislative/. No fee is charged for viewing, downloading, or printing minutes from the Internet.

EDS Update

Mary Simpson, EDS

Ms. Mary Simpson provided the Commission with a summary and analysis of the Medicaid claims processed by EDS for the first quarter of state fiscal year (SFY) 2002. (See Exhibit 3.) Ms. Simpson directed the Commission's attention to a chart representing a significant decrease in the number of enrolled providers. Ms. Simpson explained that all the providers that had not submitted a claim since January 1, 2000 were end-dated and the resulting numbers are reflected in the report. The Commission asked Ms. Simpson to find out whether there was a trend in the providers that were no longer participating in the program (i.e. did a particular specialty, such as a pediatrician, decrease) and report back to the Commission at the next meeting.

The Commission also asked Ms. Simpson to determine whether there is an industry standard for the number of dental providers that should service a particular county. Responding to a question about a reason for the increase of enrollees since 1998, Ms. Simpson stated that the increase could be in part a result of the children's health insurance program but that the question may be better directed to the Office of Medicaid Policy and Planning (OMPP).

OMPP

Susan Preble, Legislative Liaison, FSSA

Ms. Susan Preble provided the Commission with the formularies for each managed care organization (MCO) in Indiana's Medicaid program. (See Exhibit 4.) Responding to a question concerning why different MCOs are allowed to have different drug formularies, Ms Preble stated that it is a free market and that a MCO is prevented from discriminating against enrollees on a geographic basis. A Commission member stated that the fact that one MCO has 91 drugs listed on its drug formulary while another MCO only lists 25 drugs on its drug formulary is unfair.

Ms. Preble also testified and distributed a memorandum from Ms. Melanie Bella, Director, OMPP (See Exhibit 5), updating the Commission on the following topics:

Disease management: As required by HEA 1001 (2001), OMPP is continuing to develop a disease management program for Medicaid enrollees in specified counties. The four disease states are: (1) asthma; (2) diabetes; (3) congestive heart failure; and (4) AIDS. OMPP's contractor, Health Management Associates (HMA), is currently conducting data analysis and stakeholder meetings. OMPP will contract with a vendor and implement the program by July 1, 2002.

Prior authorization: Beginning January 1, 2002, OMPP will implement prior authorization for five classes of drugs: (1) brand name non-steroidal anti-inflammatory drugs and COX-2 inhibitors; (2) peptic acid disease drugs; (3) Tramadol; (4) Stadol NS; and (5) growth hormone products. Anti-anxiety drugs, antidepressant drugs, and anti-psychotic central nervous system drugs are exempt from prior authorization. OMPP continues to work with Eli Lilly and the State Mental Health Association on language documenting this exemption in the rules.

Long term care reimbursement: On October 1, 2001, OMPP implemented rules that: (1) amend the nursing facility case-mix payment methodology; (2) eliminate Medicare

crossover payments of deductibles and co-pays if the Medicare payment is greater than the Medicaid rate; and (3) eliminate bed-hold days reimbursement to nursing facilities with less than 90% occupancy.

1115 Demonstration projects: OMPP is waiting to hear from the federal government on the next grant award application for the Ticket to Work and Work Incentives Improvement Act (TWWIIA) demonstration grants. OMPP believes that this may be the most viable opportunity for a federal grant for the Indiana Comprehensive Health Insurance Association (ICHIA). OMPP has asked OASYS, the administrator of ICHIA, for data that will be needed for this grant. OMPP will update the Health Finance Commission on the status of this grant at its October 24, 2001 meeting.

Intergovernmental transfers: As instructed by SEA 309 (2001), OMPP filed a state plan amendment in March, 2001 to make additional payments to the 7 non-state governmental nursing facilities in Indiana, up to the Medicare Upper Payment Limit (UPL), as permitted by federal regulations (subject to the availability of matching funds). The Centers for Medicare and Medicaid Services (CMS, formerly HCFA), requested additional information in June, 2001. OMPP submitted a response in September, 2001. CMS has 90 days (December, 2001) to review the state plan amendment. OMPP is also reviewing whether OMPP could meet the matching fund requirements needed to receive federal funds for making additional payments to privately-owned nursing facilities. OMPP would have to submit a separate state plan amendment to receive these funds.

A Commission member commented that the legislature did not appropriate funds during the last session for a mandate that the drug utilization review (DUR) board increase its staff because the legislature felt that the money saved by the mandated pharmacy benefit Management (PBM) program would cover these costs. The Commission member stated that the intent of the legislature was to have the PBM program operating by September, 2001 and commented that Family and Social Services Administration (FSSA) is taking too long to implement the PBM program.

Responding to a question concerning whether OMPP signed a contract with a contractor for the prior authorization program before the DUR board met on the matter, Ms. Preble told the Commission that she would find out. The Commission asked for information concerning the number of consultants that FSSA contracts with, what these consultants are working on, and how much money the consultants are paid. The Commission also requested information on what cuts FSSA was making to satisfy the Governor's request for a reduction of FSSA's budget by 7%.

In response to a question regarding the percentage of denials that the DUR board has made for a request of a drug to be placed on prior authorization, Ms. Preble stated that she would find out for the Commission.

Mary Kapur, Program Director, Health Care Excel (HCE)

Ms. Mary Kapur stated that HCE also provides services for West Virginia's prior authorization program which has a 30% denial rate of drugs called in for prior authorization. Ms. Kapur stated that it costs about $6 per request in administrative costs to run West Virginia's prior authorization and estimates that Indiana's prior authorization will cost less than that. The $6 does not include costs that physicians incur in obtaining the prior authorization.

Ms. Kapur stated that its contract with Indiana will specify a response rate (i.e. the number of times the phone may ring before a HCE representative answers the call) that HCE must

meet. The personnel staffing the prior authorization telephone lines may include pharmacists and registered nurses. If the initial person does not know whether a drug should be authorized or if the reviewer believes that the drug should be denied, the request will be referred to a supervisor either in the same call or the supervisor will call the doctor's office back. Only a physician may deny authorization of a drug. An expedited appeal process will be implemented that requires a determination within 24 hours.

Responding to a question concerning the procedure for a call that occurs Friday after HCE has closed, or during a weekend or holiday, Ms. Kapur stated that the program includes a provision that allows a pharmacist to fill a 72-hour emergency supply of the drug, at no risk to the pharmacist. In response to a question concerning whether specialty doctors are consulted, Ms. Kapur told the Commission that HCE consults with over 100 physicians who specialize in many different areas and that it tries to match the request with a doctor in that field.

Dr. Ted Grisell, Clinical Director, Utilization Review, HCE

Responding to a question concerning whether the resulting costs of a prior authorization denial when an individual is hospitalized would be recorded, Dr. Ted Grisell stated that it is important to him know the cost-shifting results of a prior authorization denial. Dr. Grisell responded that he did not know how such costs could be tracked.

In response to a question concerning a Medicaid constituent whose mental health drugs were denied until the constituent used two other drugs that failed, Dr. Grisell informed the Commission that because of a maximum federal allowable charge, these drugs used to be denied. Recently, however, OMPP has decided to specifically exclude mental health drugs from this limitation and the mental health drugs will no longer be denied.

Rita Johnson-Mills, President and CEO, Managed Health Services (MHS)

Ms. Rita Johnson-Mills stated that MHS is a statewide MCO contractor, covering the northern, central, and southern Indiana regions and has operated in Indiana's Medicaid program for 5 years. Ms. Johnson-Mills informed the Commission that MHS will sometimes authorize the use of a drug if MHS believes the drug for that patient is medically necessary. MHS has a group consisting of doctors, specialists, and pharmacists that meet once a month to review issues with MHS's formulary that MHS has received from providers. In August, 2001, MHS changed its formulary in response to comments by pediatricians that more cough syrups for children needed to be covered by MHS. Responding to a question about whether any state uses a statewide-formulary and whether this would be feasible, Ms. Johnson-Mills stated that she did not know. Ms. Johnson-Mills informed the Commission that MHS may authorize a one-month supply of a prescription on prior authorization and, during that one month, meet with the physician and walk through the protocols for that particular drug. The Commission asked Ms. Johnson-Mills to find out the number of drugs that MHS had sought prior approval for and the number of those requests that were approved by the DUR board. The Commission also asked Ms. Johnson-Mills to determine the percentage of business and the percentage of providers that MHS contracts with for the North region, specifically Lake County.

Dr. Karen S. Amstutz, Medical Director, MDwise

Dr. Karen Amstutuz told the Commission that MDwise services Indiana's central region. Responding to a question concerning why there are only 25 drugs on MDwise's drug formulary, Dr. Amstutz stated that in compiling its drug formulary, MDwise first reviewed generic drugs, then looked at single-source drugs, and finally reviewed growth hormone

drugs, looking primarily at medical necessity. In response to a question about why MDwise does not use MHS's drug formulary since it used to be part of MHS, Dr. Amstutz stated that MDwise used a separate drug formulary even when MDwise was a part of MHS.

Mr. Gary Fitzgerald, Director, Government Programs and Compliance, Harmony Health Plan

Mr. Gary Fitzgerald informed the Commission that Harmony's formulary is based on prior experience Harmony had in other states before contracting with Indiana. Responding to a question concerning prior approval requests, Mr. Fitzgerald stated that Harmony has only had thirty prior approval requests and Harmony did not deny any of those requests.

Prior Authorization

Charlie Hiltunen

Mr. Charlie Hiltunen informed the Commission that the DUR board approved a prior authorization program for five categories of drugs on October 12, 2001. Mr. Hiltunen expressed his disappointment that this program was approved. Mr. Hiltunen further informed the Commission that the DUR board was told at this meeting that HCE, a candidate for the contract on this program, had already signed a contract with the state for this program. Mr. Hiltunen stated that during the DUR board meeting, data was presented that reflected a disadvantage for not using the proposed prior authorization drugs. This data was not refuted by HCE.

Mr. Hiltunen stated that he is currently working with Pfizer on enhanced protocols for drug utilization to help identify and prevent fraud, abuse, and mistake.

Dr. Emad Rahmani, IU Medical Group

Dr. Emad Rahmani presented a Power Point presentation regarding the economics of treating the chronic symptoms of mucosal damage produced by the abnormal reflux of gastric contents into the esophagus, GERD, with PPI drugs versus H2RA drugs. (See Exhibit 6 for a copy of the presentation.) Dr. Rahmani stated that people who do not have access to medication will ultimately see a specialist who will perform an expensive surgery.

Pharmacy Benefit Management

Representative Crosby provided the Commission with a handout detailing Florida's PBM program. (See Exhibit 7.) Representative Crosby also distributed an article from the New England Journal of Medicine titled Effects of Medicaid drug-payment limits on admission to hospitals and nursing homes. (See Exhibit 8.) Representative Crosby stated that New Hampshire passed legislation limiting the number of prescriptions Medicaid would cover to three prescriptions per month. After this law passed, the number of nursing home admissions in New Hampshire increased.

Mr. Mark Steck, Vice President, GM PBMS, Consultec

Mr. Mark Steck gave a Power Point Presentation on PBM services in government-sponsored programs. (See Exhibit 9 for a copy of the presentation.) Consultec has operated PBM programs in a number of other states. PBM services include administrative and care management components. Governmental PBM programs focus on the Medicaid contract, include government regulation and oversight, and service a vulnerable population and focus on administrative services, systems, and specific orientation of clinical

programs.

Responding to a question concerning the amount of time needed to implement a PBM program, Mr. Steck stated that Consultec implemented Florida's PBM program in two months. Mr. Steck commented that it is important to include physicians in a PBM program so that coordination of care occurs. Further, Mr. Steck noted that administrative efficiency (such as a quick response time) between the PBM contractor and the physician is very important.

Jerry Dubberly, Clinical Director, Consultec

Mr. Jerry Dubberly discussed the key conceptual and operational features of a PBM program. Mr. Dubberly stated that Consultec operates an inbound call center where staff pharmacists take calls from physicians as well as an outbound call center where pharmacists call physicians to discuss recommendations in therapy and drug interaction. Consultec also operates a program where pharmacists visit physicians' offices to discuss particular prescribing patterns of a physician. (See Exhibit 9 for a description of these programs.) Responding to a question concerning response rates, Mr. Dubberly commented that Consultec's average answer time for an incoming phone call is fifteen seconds.

Fraud/Abuse/Mistake

Allison Moore, Health Watch Technologies (HWT)

Ms. Allison Moore gave a Power Point presentation to the Commission. (See Exhibit 10.) Ms. Moore told the Commission that HWT provides solutions to manage health services costs, including fraud, abuse, and waste detection in public and private health care systems. HWT operates programs in Kentucky, New York, West Virginia, Florida, Washington, and Maine. HWT developed software that uses algorithms to detect medical billing errors. When developing an individualized program for a government, HWT reviews all of the government's data (billing, reports, etc.) from the previous three to five years. Once the data is collected, HWT can recover money within sixty to ninety days.

Ms. Moore stated that HWT's program in Kentucky is CMS approved and that Washington's program is receiving CMS enhanced funding. Responding to a question concerning the enhanced funding, Ms. Moore told the Commission that Washington is receiving the enhanced funding (a federal matching rate of 90% instead of the usual 75%) because of HWT's software. In response to a question concerning what HWT charges its customers, Ms. Moore stated that if its contract is on a contingency basis, HWT receives between 18%-28% of the recovery received by the state. Ms. Moore responded that HWT can also work on a fee for service basis. Ms. Moore stated that in Kentucky, which has a $2.2 billion state and federal Medicaid budget, HWT recovered $7.7 million.

Responding to a question concerning how HWT would implement a program for Indiana, Ms. Moore replied that HWT would begin by gathering data and reviewing Indiana's policies to locate possible loopholes. HWT would then load the data, run its software program, and detect possible recoveries.

Senator Miller scheduled the next meeting of the Commission for November 6, 2001 at 1:00 P.M. and adjourned the meeting at 4:20 P.M.